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Targeted Health Insurance in India: A Review of Context and Design

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ABSTRACT:
The medical poverty trap in Low and middle income countries is essentially because of loss of income and household financial security due the illness and death of family members. Breaking medical poverty nexus has become one of the most debated issues in the Indian health policy arena. The issues of day today health care cost like medicine and OPD which actually contribute more to the impoverishment of household. The various reviews of RSBY schemes are showing contradictory evidences. While some of the studies are showing that the RSBY and RSBY + schemes are actually reducing the out of Pocket Expenditure and catastrophic cost in health care, some other studies are showing that the impact is not as much as we would like to be. Still people are spending money over and above the insurance coverage; denial rates are almost in 20% in many cases and socially, economically and geographically marginalized are still out of coverage.

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I. INTRODUCTION

In the time ofIndia's independence Dr. B.R. Ambedkar wrote[1]

"…we are going to enter into a life of contradictions. In politics we will have equality and in social and economic life we will have inequality…. We must remove this contradiction at the earliest possible moment or else those who suffer from inequality will blow up the structure of political democracy which this Assembly has so laboriously built up"

This statement holds true for most of the under developed and developing countries around the world. National health policies primarily focuses on improving the population's health status, preventing occurrence of diseases and health hazards so that entire population can live a healthy and happy life without any discrimination or insecurity and contribute towards the development of the self and society in general.[2] The relation and contradiction between national policy frame work and national priorities defines governance and inclusive development of the citizens. Most of the countries in low and middle income bracket have to struggle to achieve a rational balance between the promises made by national policies and actual realization of promises. It is a contestation about social inclusion of population and economic feasibility of the method to achieve it.[3]

The contradiction in the promises made by the countries to its citizens and changing national policies and priorities had direct influence on the life of common man.[4] The national health policies become increasingly fragmented and vertical, with the increasing emphasis on selected diseasebased interventions and new entities for various health issues. Little emphasis was put on comprehensive health service delivery. These trends were in contrast to the stated aims of integrating health policy making with the broader development agenda or with comprehensive health sector planning. The effect of these phenomenas actually adversely affected the concept of equity in health access especially for poor.[5]

Health expenditure and raising impoverishment in India

Countries from low and middle income block have the highest concentration of out of pocket expenditure. WHO report shows that out of 29 countries where the out of pocket expenditure is more than 60 % of total health expenditure, 19 countries belong to the economic bracket of less than $1000 per capita annual income. Only 2 countries from $10000 group fall into the same category. The International Labour

[1] Action Points for the development of SC and ST, Planning Commission, Http://planningcommission.nic.in/plans/stateplan/scp_tsp/82ACTIONPOINTS.pdf as accessed on 3/02/2012
[2]Hogstedt, C. et. al (Ed), 2008, ' *Health for All? A Critical Analysis of Public Health Policies in Eight European Countries*' , Swedish National institute of Public Health, Ostersund, , ISBN 978-91-7257-572-1
[3]Drouin A, 2007, ' *Methods of Financing Health Care : A Rational Use of Financing Mechanisms to Achieve Universal Coverage*' , Technical Commission on Statistical, Actuarial and Financial Studies World Social Security Forum, Moscow, 10-15 September
[4] Haddad, S, Bans, E, , Narayana.D, (Ed.) 2008 *op cit*
[5]Ollila. E, 2005, ' Global Health Priorities – Priorities of the Wealthy?' , *Globalization and Health*, 1:6 doi:10.1186/1744-8603-1-6

Organization's data[6] on universal health coverage reflect that the countries where predominant system of health financing is out of pocket expenditure, the health coverage is low. Countries of African and South Asian Region have universal health coverage of less than 40% . The reason for this low universal health coverage may be linked to the lower public spending for health care and higher cost of treatment. The interplay of these two factor results in inequity in health access. In most of the countries the per capita spending on health care is also low. The per capita expenditure on health countries in African Region and South Asian Region is less than $ 50.

The 2009 WHO statistics, also points out to the fact that in South Asian Region private expenditure on health is as high as 66% of total expenditure followed by African Region where it is 53%. In low income countries the same is as high as 64% followed lower middle income countries where the private expenditure on health stands at 59%. The share of out of pocket expenditure in private expenditure is almost 89% in low and middle income countries.

Historically in India investment by government in health care has been inadequate to meet demands of the people. The Country has over the years never spent more than 4.5% of the total GDP(Public + Private). The lowest allocation was for 1994-95 was 2.63% far low from recommended 5%. Due to Structural Adjustment Programme (SAP) there was further compression in government spending in an effort to bring down fiscal deficit. The grants from central government to the state governments declined drastically from 19.9% in 1974-82 to 3.3% in 1992-93 to a figure around 2% in 2007- 2008. The share of central grants for public health declined from 28% in 1984-85 to 17% in 1992-93 to 7 % in 2004-2005 and marginally increased to 10 % in 2007-08.[7] The Percentage of GDP in health in this period remained at 4.13% in 2007-08.

Although in absolute money term the allocation have been increased as the GDP increased at a rapid and favorable rate but the consistent and reducing allocation failed to meet the requirement of public health system keeping in mind the increase in cost for procedures, infrastructure cost, human resource cost and incentive making it equal to a similar amount over three decades.[8]

The effect of the fall on the public financing of health care had a direct impact on the increasing level of poverty. The Planning commission analysis of NSSO[9] data shows that due to the falling public expenditure the out-of-pocket (OOP) expenditure in the country is increasing. Households, on average, spend about 5.8 % of all their expenditure to health care. Health accounts for about 10.5 % of nonfood expenditure[10]. Approximately 14 % of households in rural areas and 12 % in urban areas spend more than 10 % of their total annual consumption expenditure on health care[11] . In 2004, NSSO estimated that drug purchases represented between 45 % and 55 % of all inpatient expenses and between 70% and 80% of outpatient expenses incurred by households. Although private hospitals cost significantly more than government facilities, the latter are far from "free." Patients in government hospitals have to pay out-of-pocket costs of user fees, medicines, and other supplies[12]. There is also evidence of informal payments.Further analysis showed increase in poverty by as much as 3.6% and 2.9% for rural and urban India respectively, if OOP health expenditures are accounted for.[13]The analysis of 60th round suggested that around 6.2% of total households (6.6% in rural areas and 5% in urban areas) fell BPL as a result of total healthcare expenditure in 2004. Around 1.3% of total households (1.3% in rural areas and 1.2% in urban areas) fell BPL as a result of expenditure on inpatient care, while 4.9% of households (5.3% in rural areas and 3.8% in urban areas) fell BPL as a result of outpatient care[14]. In absolute terms, around 63.22 million individuals or 11.88 million households were pushed BPL due to healthcare expenditure in 2004. Moreover, much of this impoverishment (79.3%) is due to outpatient care which involves relatively small but more frequent payments, and 20.7% of impoverishment is due to inpatient care. Furthermore, much of the impoverishment (76.5% of households or 77.4% of individuals) occurs in rural areas. According to 2001 Census, 27.8% of India's population lives in urban areas, whereas only 22.6% of total healthcare related impoverishment occurs in urban areas[15].This estimate however does not include loss of wages, the attendant and transportation costs incurred by the patient. If these were included then the OOP estimation will lead to an increase in the percentage of people falling below the poverty line.[16]

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[6] *ibid*

[7] Nandraj.S, 1997, ' Unhealthy Prescriptions: The Need for Health Sector Reform in India, Informing and Reforming' , The *Newsletter of the International Clearinghouse of Health System Reform Initiatives ICHSRI*, April-June 1997, pp. 7-11

[88] National Health Profile 2011

[9] Round 55th 60th 61st , Indrani Gupta

[10] National health accounts 2010

[11] Ministry of statistics 2004

[12] NSSO 2004

[13] Indrani Gupta, 2009, ' *Out-of-Pocket Expenditures and Poverty: Estimates From NSS 61st Round*' , Paper presented for to the Expert Group on Poverty, Planning Commission 12 May 2009

[14] Berman,P Et al **The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings.** Economic & Political Weekly april 17, 2010 vol xlv no 16

[15] Ibid

[16] Indrani Gupta opcit

The current annual per capita public health expenditure in the country is just about Rs.200.

During the reform period situation in unorganized sector and rural areas changed dramatically. There was a sharp reduction on central expenditure on anti povertyprogrammes and inability of the state governments to meet fiscal deficit created by decline in central fund pushed more people into the poverty bracket. The reduction of rural agriculture and non agriculture employment and employment opportunities, increase in PDS prices and reduction on fertilizer and seed subsidy and conversion of farm land to SEZ pushed rural population towards urban area, decreasing the industrial protection to the unorganized sector and temporary labour force. The worst sufferers of the reforms are the disabled, lower caste and women who are poor.[17][18]

The above evidence actually proves that there is a linier correlation between the health sector reforms, increasing raise in cost of medical care and impoverization of individuals and household both in BPL and APL category.

Indian national policies in post reform period mostly favoured insurance as a potential tool to address the issue of health equity. The National Population Policy (NPP) 2000[19] envisaged the establishment of a family welfare-linked health insurance plan. The National Health Policy 2002 aimed to evolve a policy structure, which reduces such inequities and allows the disadvantaged sections of the population a fairer access to public health services. It seeks to increase the public investment in health through increased contribution from the central and state governments and encourages the setting up of insurance for increasing coverage of the secondary and tertiary sector. Tenth and Eleventh Five Year Plan (2002-07)focused on exploring alternative systems of health care financing including health insurance so that essential, need-based and affordable health care is available to all. NRHM on its mission documents speaks about alternative health financing through insurance model and public private partnership in health financing. Although India had some health insurance schemes the new conducive environment provided a boost to the private and community based health insurance.

India is a low-income country with over 26% [20]population living below the poverty line. Insurance provides coverage to only a small proportion of people in the organized sector covering less than 15% of the total population with most of existing schemes focusing on hospital expenses. The available insurance model only target a specific groups of people mostly in organized employment, public service or who can afford to pay for the insurance.

Whose interest does the targeted and localized insurance schemes serve?

The major targeted health insurance schemes in India are ESI, CGHS, RSBY, and various RSBY Plus models in Tamilnadu, Andhra Pradesh, Karnataka, Himachal Pradesh etc. As all of these programmes are state sponsored therefore the portion of premium is generally paid by the government. The premium in RSBY and RSBY + schemes cost from average Rs.400 to Rs.1000 per individual to the state. The cost of premium for ESI and CGHS are far more. However in the coverage sides most of the schemes are focused mainly on inpatient care that to mainly tertiary and super specialty care. The OPD services are not covered which is the most important reason for medical impoverishment. Maternity services are excluded as it is already covered under NRHM-JSY. Evidences shows that patient still have to incur out of pocket expenditure availing Inpatient services. Survey conducted in Andhra Pradesh shows that 58% of the Rajiv Aarogyasri Scheme patients reported having incurred OOP expense with an average Rs. 3,600 per patient. Even in Kerala, RSBY patients have reported paying additional OOP charges.

The composition of facility providers shows a very interesting picture. Most of these schemes are dependent on network of empanelled private hospital. RSBY having the largest no of empanelled hospitals shows a national average of 68% private hospital as place for treatment. The same stands at 94% for Yashasvini, 97% for Kalaignar, 95% for Karnataka arogyashree and 71% for Arogyashree in Andhra Pradesh[21]. Hospital wise claims data points towards the trend in which government schemes are tilting funds to the already flourishing private hospitals while the public hospitals are starved for funds. Apart from tilting balance in favour of private providers, it has been also observe wide variation in package rates; the schemes are paying different and generally higher package rates across the states in the absence of any standardization or norms for provider networks.

[17]Mahendra Dev. S, 1995, ' Economic Reforms and the Rural Poor' , *Economic and Political Weekly*, Vol. 30, No. 33 pp. 2085-2088

[18]Seema Joshi, *2005 Op cit*

[19] National Population Policy – 2000, Govt of India

[20] World bank http://www.worldbank.org.in/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/INDIAEXTN/0,,contentMDK:21880725~pagePK:141137~piPK:141127~theSitePK:295584,00.html as accessed on 10/03/2012

[21]A Critical Assessment of the Existing Health Insurance Models in India, Sponsored under the Scheme of Socio-Economic Research, The Planning Commission of India, New Delhi 2011

The above variation in package cost does not show any direct correlation with the cost of health care at state level but a complex negation amongst the stakeholder for profit maximization.

Regarding the implementation and management of scheme, all these schemes are being implemented by the government, but the management of the same remains with the private players. If it is reviewed that who is managing the and insuring the members its mainly the insurance companies and the TPA who practically run the show. The RSBY and all RSBY + and derivatives schemes actually outsourced the entire insurance technicalities to private insurance companies and Respective TPAs manage the claim processing, reimbursement to hospital, package calculation and denial redressal.[22]

The data for these schemes show another interesting trend ofdominance in claim by Private hospitals. Nearly 60% claims under VajapayeeArogyasri and Yeshasvini were made by a few hospitals in Karnataka. Rajiv Aarogyasri scheme also has 34% claims and Kalaignar scheme has 26% claims made specific sets of network hospitals. RSBY Plus has 100% of claims coming from top 20 hospitals in Himachal Pradesh. For Yeshasvini figures, NarayanaHrudayalaya (NH) alone claimed 32% of total amount claimed amounting for 15% of the total cases in 2008-09[23].Since outpatient care is not covered by most schemes; patients also have an incentive to substitute inpatient for outpatient care showing evidence of unnecessary care. The review of RSBY found that certain hospitals perform many more hysterectomies than would be expected, or combine hysterectomies with simultaneous salpingoopharectomies which entitles the facility to claim additional charges. There were similar claims for hernia combined with appendectomy to maximize revenues from the scheme. Monitoring data from Aarogyasri (AP) also suggests that certain procedures (e.g., appendectomy, hysterectomy, laminectomy/discectomy, and renal stone lithotripsy) were experiencing provider induced demand.

Another question arises why suddenly the growing interest towards govt. sponsored targeted insurance. The answer remains at the economics of volume and market. The World Bank report on targeted health insurance in India[24] speculates that spending through health insurance mechanisms will continue to increase at annual growth rate of 19 percent per annum, reaching Rs. 38,000 crores by 2015. Government supported insurance schemes will account for about 40 percent of the total i.e. around Rs. 15500 crores; private insurers will insure most amount. In 2015, spending through health insurance will reach 8.4 percent of total health spending, up from 6.4 percent in 2009–10. The government spending on these targeted insurance schemes account for 24, 41, and 6 percent of government spending by the Govt. of india , Andhra Pradesh Govt. , and Karnataka Govt. , respectively in 2008–09 out of which majority of the resources claimed by Private facilities.

The calculation shows that the entire decision to adopt a targeted insurance approach is creating a market which is otherwise not possible for the insurance companies to tap in conventional ways rather that address the issues of poverty, access and equity.

II. CONCLUSION

The medical poverty trap in Low and middle income countries is essentially because of loss of income and household financial security due the illness and death of family members.[25] Although many schemes have been launched till date, the health coverage is least for those who need it the most. Breaking medical poverty nexus has become one of the most debated issues in the Indian health policy arena. Health policy makers and health economist supporting health insurance gives the arguments that that in the absence of health insurance the effect of high OOP expenditure will clearly impact on poverty, pushing those who are slightly above poverty line into below poverty line and those already below poverty line into further impoverishment.[26]Another group argues that may be strengthening the public health system may be answer as it will provide a assure set of services to the population. Another group tries to look health insurance as a stop gap arrangement till Indian economy and Indian health system is able to develop and design a comprehensive National Health services. But in the entire debate the Population's belonging to below and slightly above poverty line, urban poor, middle class population engaged in secondary and tertiary industries, women withlow or no income and other socially excluded groups are lost in.The issues become worse for the lower caste people who cannot afford to pay CHI premium or cannot be member of CHI because of social construct.[27] Study by Fan, Karan, and Mahal reported effects on inpatient expenditure were not as robust for households from scheduled castes and scheduled tribes (SC/ST). This suggests that schemes may not be as effective in reaching out to SC/ST communities.

The question that remains - who health system is strengthening? Is it the public health sector, the private health sector, the insurance companies, the third party administrator? The question is conveniently

[22]Swarup A., Jain N., (2010) "RSBY –A casestudy from India", Ministry of Labour and Employment, Government of India, New Delhi, www.rsby.gov.in.

[23] Data f

[25]Rugers, J. 2006, ' Measuring Disparities in Health Care', *British Medical Journal* ,333; pp. 274

[26]Seema Joshi, *2005 Op cit*

[27]Saikia K, 2010 *Op cit*

disappeared in the higher debate of reducing the catastrophic cost of health care so also the question of how to address the issues of day today health care cost like medicine and OPD which actually contribute more to the impoverishment of household. The focus on spending more on provisioning tertiary and super specialty care and not preventive and primary care with in insurance design framework also increasing the catastrophic cost on health care as the basic provisioning are insufficient to reduce the severity of the health incident. So can we have a model where insurance also provides preventive and primary care? Does the economics of insurance make it feasible to provide those services? Govt of India let alone World Bank, Insurance Lobby or Private Hospitals actually thinks otherwise.[28]Who benefit from the schemes whether it is the poorest of the poor or insurance companies or the government, we still do not know. The various reviews of RSBY schemes areshowing contradictory evidences. While some of the studies are showing that the RSBY and RSBY + schemes are actually reducing the out of Pocket Expenditure and catastrophic cost in health care, some other studies are showing that the impact is not as much as we would like to be. Still people are spending money over and above the insurance coverage; denial rates are almost in 20% in many cases and socially, economically and geographically marginalized are still out of coverage. So who is benefiting – Insurance companies , and private hospitals for sure, Government also for sure because the health allocation andspending has going up superficially, the people –not sure , Public Hospitals – they are in a dismal state of affairs.

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